National Electronic Data Interchange
Transaction Set Implementation Guide

Health Care Service: Data Reporting

837

ASC X12N 837 (004050X156)

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1 Purpose and Business Overview

1.1 Document Purpose

For the health care industry to achieve the potential administrative cost savings with Electronic Data Interchange (EDI), standards have been developed and need to be implemented consistently by all organizations. To facilitate a smooth transition into the EDI environment, uniform implementation is critical. Health care providers, health care payers, and local, state and federal governmental authorities and their reporting agents utilize health care services data. The health care services data is critical information that measures utilization rates, provides health data statistical analysis from provider data, and satisfies governmental legislative mandates necessary to regulate the health care industry.

This is the implementation guide for the ANSI ASC X12N Health Care Services for reporting health care services data. This implementation guide provides standardized data requirements and content utilizing the 837 Health Claim transaction set standards. This guide is not intended to meet the needs of all health care services data reporting. It is intended to provide a standard implementation for reporting systems that currently utilize or are capable of utilizing the 837 health care claims transaction set standard. This implementation guide provides a definitive statement of what data translators must be able to handle in this version of the Health Care Services Data Reporting guide.

1.1.1 HIPAA Role in Implementation Guides

The Health Insurance Portability and Accountability Act of 1996 (P.L. 104-191 - known as HIPAA) includes provisions for Administrative Simplification, which require the Secretary of Department of Health and Human Services to adopt standards to support the electronic exchange of administrative and financial health care transactions primarily between health care providers and plans. HIPAA directs the Secretary to adopt standards for transactions to enable health information to be exchanged electronically and to adopt specifications for implementing each standard.

Detailed Implementation Guides for each standard must be available at the time of the adoption of HIPAA standards so that health plans, providers, clearinghouses, and software vendors can ready their information systems and application software for compliance with the standards. Consistent usage of the standards, including loops, segments, data elements, etc., across all guides is mandatory to support the Secretary's commitment to standardization.

This implementation guide is intended to be Compatible, but not compliant with the data standards set out by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and its associated rules. Although public agencies are technically exempt from HIPAA's transaction and code set regulations, unless

they are providers or health plans, the covered entities (data suppliers) are not and must comply. The industry claim/encounter transaction standard, while uniform, does not meet the broader uses of public agencies, so local, state, and federal agencies have modified the standard to meet local needs. This results in reporting variability across public agencies and challenges multi-state reporting and collection of administrative data. This guide seeks to promote less variability and more comparability across States.

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1.2 Version and Release

This implementation guide is based on the October 2001ASC X12 standards, referred to as Version 4, Release 5, Sub-release 0 (004050).

1.3 Business Use and Definition

The ASC X12N standards are formulated to minimize the need for users to reprogram their data processing systems for multiple formats by allowing data interchange through the use of a common interchange structure. These standards do not define the method in which interchange partners should establish the required electronic media communication link, nor the hardware and translation software requirements to exchange EDI data. Each trading partner must provide these specific requirements separately.

This implementation guide is intended to provide assistance in developing and executing the electronic transfer of health care systems data for reporting purposes to local, state, and federal agencies that utilize the data for monitoring utilization rates, assessing patterns of health care quality and access, and other purposes required by legislative and regulatory mandates. This Guide will provide a definitive statement of reporting standards to permit the translation of many formats to one common format. Beginning with the ANSI ASC X12N 837 Institutional transaction, this Guide provides consensus standards and content definitions for publicly reporting of health care services data that will meet common state and private reporting needs for utilization, cost, and quality applications.

The ANSI X12N 837 Institutional data elements common to public reporting have been identified and mapped to this Guide. Additional fields have been identified. This guide will not address all public health and research reporting requirements. Through the Public Health Data Standards Consortium and its partners, consensus priority data elements have been identified and standard definitions and formats proposed.

1.3.1 Terminology

Certain terms have been defined to have a specific meaning within this guide. The following terms are particularly key to understanding and using this guide.

Bill
A statement of charges for treatment or services rendered to a patient by the medical provider.

Claim/Encounter
A reported event resulting in bodily injury, sickness, or disease or another reason for a health care visit with a provider. A claim/encounter can have multiple bills.

Patient
The term “patient” is the person that sustained the injury, sickness, or disease or otherwise required health care services. In some instances, the patient may not be the same person as the subscriber/named insured, and the patient is a person (e.g. spouse, children others) who is covered by the subscriber’s insurance plan. However, it also happens that the patient is sometimes the same person as the subscriber/named insured.

Provider
In a generic sense, the provider is the entity that originally submitted the bill. A provider may also have provided or participated in some aspect of the medical care service described in the transaction.

Subscriber
The subscriber is the person whose name is listed in the health insurance policy. Other synonymous terms include “member” and/or “insured.” In some cases, the subscriber is the same person as the patient. See the definition of patient for further details.

1.4 Information Flows

The Health Care Services Data Reporting Guide is intended to transmit health care services data from health care providers to local, state and federal agencies. This information can be transmitted directly from providers or their agents to the governmental agencies or can be transmitted from payer organizations to the governmental agency. Local, state, or federal legislation dictates the transmission source of the data. The health care service data collected is used in health data statistical analysis, to satisfy governmental legislative mandates, to measure utilization rates , and as part of the governmental regulatory functions. State discharge data system data needs are the first to be accommodated by the contents of this guide.

2 Data Overview

The data overview introduces the 837 transaction set structure and describes the positioning of business data within the structure. The implementation guide developers recommend familiarity with ASC X12 nomenclature, segments, data elements, hierarchical levels, and looping structure. For a review, see Appendix A, ASC X12 Nomenclature, and Appendix B, EDI Control Directory.

2.1 Overall Data Architecture

Two formats, or views, are used to present the transaction set — the implementation view and the standard view. The implementation view of the transaction set is presented in Section 2.1, Overall Data Architecture. See figure 1, 837 Transaction Set Listing, for the implementation view. Figure 1 displays only the segments described in this implementation guide and their designated health care names. The standard view, which is presented in Section 3, Transaction Set, displays all segments available within the transaction set and their assigned ASC X12 names.

The intent of the implementation view is to clarify the segments' purpose and use by restricting the view to display only those segments used with their assigned health care names.

INSERT FIGURE 1.
837 Transaction Set Listing

2.2 Loop Labeling and Use

For the user's convenience, the Health Care Service Data Reporting transaction uses two naming conventions for loops. Loops are labeled with a descriptive name as well as with a shorthand label. Loop ID-1000A SUBMITTER NAME contains information about the individual or organizational entity that submitted the transaction. The descriptive name – SUBMITTER NAME - informs the user of the overall focus of the loop. The shorthand name -1000A - gives, at a glance, the position of the loop within the overall transaction. The receiver information is labeled Loop ID-1000B RECEIVER NAME and Loop ID-2000A Service Provider. The shorthand labels for these loops are 1000B and 2000A.

The 837 format is logically organized to provide an efficient vehicle to transmit claim/encounter data between submitter and receiver entities. The loops in the 837 standard and the hierarchical relationships between these loops create the data structures for this transaction set.

Loops may be reported only once or may be repeated depending on the intended function of the loops. This implementation guide is presented in a "flattened out" format that shows multiple iteration of sub-loops so that each loop's use is clear. Not all loops are required to be used.

2.3 Data Use by Business Use

The 837 is divided into two levels, or tables. The Header level, Table 1, contains transaction control information. The Detail level, Table 2, contains the detail information for the transaction's business function and is presented in 2.3.2, Table 2 — Detail Information.

INSERT FIGURE 2.
Table 1 – Header Level

2.3.1 Table 1 — Transaction Control Information

Table 1 is named the Header level (see figure 2, Header Level). Table 1 identifies the start of a transaction, the specific transaction set, and the transaction's business purpose. Additionally, when a transaction set uses a hierarchical data structure, a data element in the header BHT01 — the Hierarchical Structure Code — relates the type of business data expected to be found within each level. (increments sequentially)

2.3.1.1 837 Table 1 — Header Level

The following is a coding example of Table 1 in the 837. Refer to Appendix A, ASC X12 Nomenclature, for descriptions of data element separators (e.g., *) and segment terminators (e.g., ~).

ST*837*0001~
ST01 837 = Transaction set identifier code
ST02 0001 = Transaction set control number

BHT*0019*00*24375Y*20010715*0555*RP~
BHT01 0019 = Hierarchical structure code (information source, subscriber, dependent)
BHT02 00 = Original
BHT03 24375Y = Submitter's batch control number
BHT04 20010715 = Date of file creation
BHT05 0555 = Time of file creation
BHT06 RP = Reporting (claims/encounter)

REF*87*004050X156~

REF01 87 = Functional Category
REF02 004050X156 = Reference Identification

The Transaction Set Header (ST) segment identifies the transaction set by using 837 as the data value for the transaction set identifier code data element, ST01. The transaction set originator assigns the unique transaction set control number ST02, shown in the previous example as 0001.

The Beginning of Hierarchical Transaction (BHT) segment indicates that the transaction uses a hierarchical data structure. The value of 0019 in the hierarchical structure code data element, BHT01, describes the order of the

hierarchical levels and the business purpose of each level. See Section 2.3.1.2, Hierarchical Level Data Structure, for additional information about the BHT01 data element.

The BHT segment also contains the transaction set purpose code, BHT02, which indicates an **original transaction** by using data value 00 or a **reissue (resubmitted) transaction** by using data value 18.

The submitter's business application system generates the following fields:

BHT03, originator's reference number;
BHT04, date of transaction creation;
BHT05, time of transaction creation and
BHT06, transaction type code. BHT06 is used to indicate the electronic transmission status of the 837 batch, not the billing status. The BHT06 must indicate RP for Reporting.

Because the 837 is multi-functional, it is important for the receiver to know which business purpose is served, so the REF in the Header is used. A data value of 87 in REF01 indicates the **functional category,** or type, of 837 being sent. The appropriate value for REF02 is 004050X156 for production values or 004050X156D test values.

2.3.1.2 Hierarchical Level Data Structure

The hierarchical level (HL) structure identifies and relates the participants involved in the transaction. The participants identified in the 837 Health Care Service Data Report are generally service provider, subscriber, and patient. The 0019 value in the BHT hierarchical structure code (BHT01) the 0019 value describes the order of subsequent loops within the transaction set and refers to these participants, respectively, in the following terms:

- Information source (service provider)
- Subscriber (can be the patient when the patient is the subscriber)
- Dependent (patient, when the patient is not the subscriber)

The term "billing provider" indicates the information source in the hierarchical level (HL). The term "patient" indicates the dependent HL.

2.3.2 Table 2 — Detail Information

Table 2 uses the hierarchical level structure. Each hierarchical level is comprised of a series of loops. Numbers identify the loops. The hierarchical level that identifies the participants and the relationship to other participants is Loop ID-2000. The individual or entity information is contained in Loop ID-2010.

2.3.2.1 HL Segment

The hierarchical parent/child relationships amongst loops are defined using the HL segment. This transaction mimics real life in that everybody has a parent but

not everybody has a child. The HL segment identifies the parent and indicates when a child loop should be reported.

Below is an overview of the 837 loops and the hierarchical relationships.

- Transaction Set identifying information (HEADER Loop)
- Submitter and Receiver Information (1000 Loop)
- Provider Information (2000A Loop)

Information related to each provider is organized hierarchically.
The standard supports reporting for multiple providers.

- Subscriber / Patient Information (2000B & C Loops)

  Information related to each patient is organized hierarchically.
  The standard supports reporting for multiple patients.

- Patient Claim Information (2300 Loop)

  The standard supports reporting for multiple episodes of care for each patient.

- Service Line Information (2400 Loop)

  The standard supports reporting of multiple services for each episode of care for each patient.

The following information illustrates claim/encounter submissions when the patient is the subscriber and when the patient is not the subscriber.

NOTE
Specific claim detail information can be given in either the subscriber or the dependent hierarchical level. Because of this, the claim information is said to "float." Claim information is positioned in the same hierarchical level that describes its owner-participant, either the subscriber or the dependent. In other words, the claim information is placed at the subscriber hierarchical level when the patient is the subscriber, or it is placed at the patient/dependent hierarchical level when the patient is the dependent of the subscriber.

Claim/encounter submission when the **patient is the subscriber:**
Service provider (HL03=20) (Information Source)
Subscriber (HL03=22)
Claim level information
Line level information, as needed

Claim/encounter submission when the **patient is not the subscriber:**
Service provider (HL03=20)
Subscriber (HL03=22)
Patient (HL03=PT)
Claim level information
Line level information, as needed

Each HL may contain multiple "child" HLs. A child HL indicates a HL that is nested within (subordinate to) the previous HL. Hierarchical levels may also have a "parent" HL. A parent HL is the HL that is one level out in the nesting structure. An example follows.

Service provider HL	**Parent HL** to the subscriber HL
Subscriber HL	**Parent HL** to the patient & **Child HL** to the service provider
Patient HL	**Child HL** to the subscriber HL

For the subscriber HL, the service provider HL is the parent. The patient HL is the
child. The subscriber HL is contained within the service provider HL. The patient HL is contained within the subscriber HL.

If the Service provider is submitting claims for more than one subscriber, each of whom may or may not have dependents, the HL structure between the transaction set header and trailer (ST—SE) could look like the following:

SERVICE PROVIDER
- SUBSCRIBER #1 (Patient #1)
  - Claim level information
  - Line level information, as needed
- SUBSCRIBER #2
  - PATIENT #P2.1 (e.g., subscriber #2 spouse)
    - Claim level information
    - Line level information, as needed
  - PATIENT #P2.2 (e.g., subscriber #2 first child)
    - Claim level information
    - Line level information, as needed
  - PATIENT #P2.3 (e.g., subscriber #2 second child)
    - Claim level information
    - Line level information, as needed
- SUBSCRIBER #3 (Patient #3)
  - Claim level information
  - Line level information, as needed
- SUBSCRIBER #4 (Patient #4)
  - Claim level information
  - Line level information, as needed
  - PATIENT #P4.1 (e.g., #4 subscriber's first child)
    - Claim level information
    - Line level information, as needed

Based on the previous example, the HL structure looks like the following:

`HL*1**20*1~` (indicates the service provider)
1 = HL sequence number
** (blank) = there is no parent HL (characteristic of the service provider HL)
20 = information source
1 = there is at least one child HL to this HL

`HL*2*1*22*0~` (indicates subscriber #1 for whom there are no dependents)
2 = HL sequence number
1 = parent HL
22 = subscriber (there is no child HL to this HL - claim level data follows)
0 = no subordinate HLs to this HL (there is no child HL to this HL - claim level data follows)

`HL*3*1*22*1~` (indicates subscriber #2 for whom there are dependents)
3 = HL sequence number

1 = parent HL
22 = subscriber
1 = there is at least one child HL to this HL

HL*4*3*PT*0~ (indicates patient #P2.1)
4 = HL sequence number
3 = parent HL
PT = patient
0 = no subordinate HLs to this HL (there is no child HL to this HL - claim level data follows)
HL*5*3*PT*0~ (indicates patient #P2.2)
5 = HL sequence number
3 = parent HL
PT = Patient
0 = no subordinate HLs to this HL (there is no child HL to this HL - claim level data follows)

HL*6*3*PT*0~ (indicates patient #P2.3)
5 = HL sequence number
3 = parent HL
PT = Patient
0 = no subordinate HLs to this HL (there is no child HL to this HL - claim level data follows)

HL*7*1*22*0~ (indicates subscriber #3 for whom there are no dependents)
7 = HL sequence number
1 = parent HL
22 = subscriber
0 = no subordinate HLs to this HL (there is no child HL to this HL - claim level data follows)

HL*8*1*22*1~(indicates subscriber #4 who is a patient in their own right and for whom there are dependents)
8 = HL sequence number
1 = parent HL
22 = subscriber
1 = there is at least one child HL to this HL (claim level data follows for #4 after which comes HL*9)

HL*9*8*PT*0~ (indicates patient #P4.1 for subscriber #4)
9 = HL sequence number
8 = parent HL
PT = Patient
0 = no subordinate HLs to this HL (there is no child HL to this HL - claim level data follows)

If another service provider is listed in the same ST–SE transaction, it could be listed as follows: **HL*100**20*1~**. The HL sequence number of 100 indicates that there are 99 previous HL segments, but it is service provider level HL (HL02 = ** (blank)) and is a different entity than the first service provider listed.

From a review of these examples, the following information is noted:

- HLs are numbered sequentially. The sequential number is found in HL01, which is the first data element in the HL segment.

- The second element, HL02, indicates the sequential number of the parent hierarchical level to which this hierarchical level (HL01) is subordinate. The service provider/information source has no parent. If the data value in HL02 is equal to "** (blank)", it is known that this is the highest hierarchical level for all the contained subordinate levels. The service provider level is not subordinate to any hierarchical level.

- The data value in data element HL03 describes the hierarchical level entity. For example, when HL03 equals 20, the hierarchical level is the service provider; when HL03 equals 23, the hierarchical level is the dependent (patient).

- Data element HL04 indicates whether or not subordinate hierarchical levels exist. A value of “1" indicates subsequent hierarchical levels. A value of ”0" or absence of a data value indicates that no subordinate hierarchical levels follow.

- HLs must be transmitted in order.

2.3.2.2 NTE and K3 Segments

The use of the NTE and the 3 segments in this implementation guide is to accommodate legislated state data requirements that are not supported by the current 837 claim/encounter standard. Appropriate use of the NTE and K3 segments is to define data requirements necessary to comply with local, state, or federal statutes in a timely manner. The NTE and K3 segments are intended to report data elements only supported by submitter information systems. The intent of the NTE and K3 segments is to accommodate emergency state legislative requirements that are not accommodated by the current X12 standards.

Any use of free text data in these segments is strongly discouraged. Within the free text data elements in each of these segments (NTE02 DE 352 and K301 DE 449), users should make all attempts to use formatted codified data. Communication of the non-standard data requirements in these segments to information sources is the responsibility of the governmental agency responding to the emergency data need.

The NTE segment would be used, rather than the K3 segment, if the information needs to be qualified to insure proper processing of that data.

2.4 Loop ID-2010

2.5 Billing Information

2.6 Interactions with Other Transactions

An overview of transactions that interact with the 837 is presented here.

2.6.1 Functional Acknowledgment (997)

The Functional Acknowledgment (997) transaction is used as the first response to receiving an 837. The 997 informs the 837 submitter that the transmission arrived. In addition, the 997 can be constructed to send information about the syntactical quality of the 837 transmission.

2.6.2 Application Advice (824)

The Application Advice (824) transaction is used to explain how the 837 was

processed through the receiving system. It also gives the processing status.

2.7 Use of Data Segment and Elements Marked "Situational"

Health Care Service Data Reporting spans an enormous variety of health care data reporting requirements. Because of this, it is difficult to set a single list of data elements that are required for all types of health care reporting. To meet the divergent needs of submitters, many data segments and elements included in this implementation guide are marked "situational." All situational segments and elements have notes attached specifying when they should be used. To the greatest degree possible, situational segments and elements have had their required use specified. Some elements are used at the discretion of the submitter.

Since the intended use of this implementation guide spans a broad spectrum of uses, the overriding principle for those who choose to use this guide should be to "**ignore, but don't reject"**. By this we mean if situational data segments or elements are reported, but are not necessary for your specific application, you should ignore the information that is not needed. It is important to make sure that the unneeded information does not cause the transaction to be rejected.